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### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT STATE: <u>KENTUCKY</u>

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of	Charge		Amount and Basis for Determination
	Deduct.	Coins	Co-pay	
Prescription Drugs			X	Effective August 17, 2005: \$1 for each generic drug or atypical antipsychotic drug that does not have a generic equivalent; \$2 for each brand name drug that does not have a generic equivalent and is available under the supplemental rebate program; or \$3 for each non-preferred brand name drug. The Department for Medicaid Services (DMS) shall reduce a pharmacy provider's reimbursement by \$1 regardless of the amount of the co-payment due.  Effective January 1, 2006: A cap of \$225 per calendar year (January 1 – December 31) per recipient will apply to prescription drug co-payments.  The average payment per prescription drug is \$51.88 for FY 2005.

Service	Type of Charge		Amount and Basis for Determination		
	Deduct. Coins	Co-pay			
Audiology		X	\$2.00 for each date of service. DMS shall reduce a		
			provider's reimbursement by \$2.00. The average		
			payment for an audiology service is \$93.68 in FY 2005.		
Chiropractor		X	\$2.00 for each date of service. DMS shall reduce a		
			provider's reimbursement by \$2.00. The average		
			payment for a chiropractic service is \$39.60 in FY 2005.		
Dental		X	\$2.00 for each date of service. DMS shall reduce a		
			provider's reimbursement by \$2.00. The average		
			payment for a dental service is \$128.27 in FY 2005.		
Hearing Aid Dealer		X	\$2.00 for each date of service. DMS shall reduce a		
			provider's reimbursement by \$2.00. The average		
			payment to a hearing aid dealer is \$409.35 in FY 2005.		
Podiatry		X	\$2.00 for each date of service. DMS shall reduce a		
			provider's reimbursement by \$2.00. The average		
			payment for a podiatry service is \$61.02 in FY 2005.		
Optometry*		X	\$2.00 for each date of service. DMS shall reduce a		
			provider's reimbursement by \$2.00. The average		
			payment to an optometrist for a general		
			ophthalmological service is \$44.02 in FY 2005.		
General ophthalmological services*		X	\$2.00 for each date of service. DMS shall reduce a		
			provider's reimbursement by \$2.00. The average		
			payment for an ophthalmological service is \$29.84 in FY		
			2005.		
Office visit for care by a physician,**		X	Effective August 1, 2005: \$2.00 per visit. The average		
physician's assistant, or advanced			payment for this service is \$37.12 in FY 2005. DMS		
registered nurse practitioner			shall not reduce a provider's reimbursement by \$2.00.		
Visit to a rural health clinic, primary		X	Effective August 1, 2005: \$2.00 per visit. The average		
care center, or federally qualified			payment for this service is \$39.21 in FY 2005. DMS		
health center			shall not reduce a provider's reimbursement by \$2.00.		

\*CPT codes 92002, 92004, 92012, and 92014.

\*\*CPT codes 99201, 99202, 99203, 99204, 99211, 99212, 99213, and 99214

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Outpatient hospital service	X	Effective August 1, 2005: \$3.00 for each date of service. The average payment for this service is \$211.55 in FY 2005. DMS shall reduce a provider's reimbursement by \$3.00.
Emergency room visit for a non- emergency service	X	Effective August 1, 2005: \$3.00 per visit. The average payment for this service is \$190.77 in FY 2005. DMS shall not reduce a provider's reimbursement by \$3.00.
Inpatient hospital admission	X	Effective August 1, 2005: \$50.00 per admission. The average payment for this service is \$2512.78 in FY 2005. DMS shall reduce a provider's reimbursement by \$50.00.
		Effective January 1, 2006: A cap of \$225 per calendar year (January 1 – December 31) per recipient will apply to co-payments for services.

- B. The following shall not be subject to a copayment:
  - (a) Individuals excluded in accordance 42 CFR 447.53.
  - (b) A service provided to a recipient who has reached his or her 18<sup>th</sup> birthday but has not turned 19.

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# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT STATE: KENTUCKY

- B. The method used to collect cost sharing charges for medically needy individuals:
  - X Providers are responsible for collecting the cost sharing charges from individuals.
  - The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.
- C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Federal limits on the services for which copayment applies restrict the maximimum copayment charges. The State's scope of services is broad and eligible recipients have low, if any, out-of-pocket medical expenses; therefore, the state believes that all recipients within the class that are subject to copayments should be able to pay the required copayment.

Should a recipient claim to be unable to pay the required copayment, the provider may not deny service, but may arrange for the recipient to pay the copayment at a later date. Any uncollected amount is considered a debt to providers.

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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT STATE: KENTUCKY

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

MMIS has been programmed not to deduct copayments from claims for Medicaid recipients and services that are exempt from cost sharing as identified in 42 CFR 447.53(b). MMIS will identify the exempt recipients by age for children under age 18, by aid category and recipient status for pregnant women and institutionalized individuals. Recipients outside the exempt status will have a copayment due and printed on the Medicaid cards they receive each month. Providers will use the Medicaid card to identify those recipients who should pay a copayment.

E. (	Cumulative	maximums	on	charges:
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Х	State policy	does not	provide	for cumulative	maximilms
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ı as	s described	below
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N/A

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